

		FOR OHF USE					

LL 1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0044297</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Clearbrook - Wright Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/99</u> to <u>6/30/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>34377 N. Almond</u> <u>Gurnee</u> <u>60031</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Lake</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Carl La Mell</u> (Title) <u>President</u>	
Telephone Number: <u>847-870-7711</u> Fax # <u>847-870-9926</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # () _____	
IDPA ID Number: <u>36-3523962</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>07/07/92</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.		<input type="checkbox"/> PROPRIETARY	
<input type="checkbox"/> Trust		<input type="checkbox"/> Individual	
IRS Exemption Code <u>501C3</u>		<input type="checkbox"/> Partnership	
		<input type="checkbox"/> Corporation	
		<input type="checkbox"/> "Sub-S" Corp.	
		<input type="checkbox"/> Limited Liability Co.	
		<input type="checkbox"/> Trust	
		<input type="checkbox"/> Other _____	
In the event there are further questions about this report, please contact: Name: <u>Kathleen Appleton</u> Telephone Number: <u>847-870-7711x240</u>			

Facility Name & ID Number Clearbrook - Wright Home# 0044297 Report Period Beginning: 7/1/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>15</u>	ICF/DD 16 or Less	<u>15</u>	<u>5,490</u>	6
7	<u>15</u>	TOTALS	<u>15</u>	<u>5,490</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,228</u>			<u>5,228</u>	13
14	TOTALS	<u>5,228</u>			<u>5,228</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.23%

D. How many bed-hold days during this year were paid by Public Aid?

262 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 08/02/93

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date 07/07/92 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 7/1/99 Fiscal Year: 6/30/00

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Clearbrook - Wright Home

0044297

Report Period Beginning:

7/1/99

Ending:

6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	27,007			27,007		27,007		27,007		1
2	Food Purchase		25,593		25,593		25,593		25,593		2
3	Housekeeping		5,260		5,260		5,260		5,260		3
4	Laundry			17,630	17,630		17,630		17,630		4
5	Heat and Other Utilities										5
6	Maintenance	19,477	5,922	26,902	52,301		52,301	5,372	57,673		6
7	Other (specify):*										7
8	TOTAL General Services	46,484	36,775	44,532	127,791		127,791	5,372	133,163		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	393,475	44,528		438,003		438,003		438,003		10
10a	Therapy										10a
11	Activities		2,257		2,257		2,257		2,257		11
12	Social Services										12
13	Nurse Aide Training										13
14	Program Transportation			1,858	1,858		1,858		1,858		14
15	Other (specify):* Program consultants			119,018	119,018		119,018		119,018		15
16	TOTAL Health Care and Programs	393,475	46,785	120,876	561,136		561,136		561,136		16
	C. General Administration										
17	Administrative	24,757			24,757		24,757	29,632	54,389		17
18	Directors Fees										18
19	Professional Services							4,571	4,571		19
20	Dues, Fees, Subscriptions & Promotions			227	227		227	1,859	2,086		20
21	Clerical & General Office Expenses	24,992	1,302		26,294		26,294	21,545	47,839		21
22	Employee Benefits & Payroll Taxes			72,460	72,460		72,460	13,026	85,486		22
23	Inservice Training & Education							9,813	9,813		23
24	Travel and Seminar			647	647		647		647		24
25	Other Admin. Staff Transportation							919	919		25
26	Insurance-Prop.Liab.Malpractice			7,344	7,344		7,344	1,053	8,397		26
27	Other (specify):* See page 24			22,186	22,186		22,186		22,186		27
28	TOTAL General Administration	49,749	1,302	102,864	153,915		153,915	82,418	236,333		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	489,708	84,862	268,272	842,842		842,842	87,790	930,632		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number

Clearbrook - Wright Home

#0044297

Report Period Beginning:

7/1/99

Ending:

6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			39,234	39,234		39,234		39,234			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,980	53,980		53,980	2,040	56,020			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			93,214	93,214		93,214	2,040	95,254			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			44,792	44,792		44,792		44,792			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			44,792	44,792		44,792		44,792			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	489,708	84,862	406,278	980,848		980,848	89,830	1,070,678			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Clearbrook - Wright Home

0044297

Report Period Beginning:

7/1/99

Ending:

6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1	\$	1
2		2
3		3
4		4
5		5
6		6
7		7
8		8
9		9
10		10
11		11
12		12
13		13
14		14
15		15
16		16
17		17
18		18
19		19
20		20
21		21
22		22
23		23
24		24
25		25
26		26
27		27
28		28
29		29
30		30
31		31
32		32
33		33
34		34
35		35
36		36
37		37
38		38
39		39
40		40
41		41
42		42
43		43
44		44
45		45
46		46
47		47
48		48
49		49
50		50
51		51
52		52
53		53
54		54
55		55
56		56
57		57
58		58
59		59
60		60
61		61
62		62
63		63
64		64
65		65
66		66
67		67
68		68
69		69
70		70
71		71
72		72
73		73
74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90 Total	0	90

Summary A

6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Summary B

6/30/00

Summary B

[illegible]

Facility Name & ID Number Clearbrook - Wright Home

0044297

Report Period Beginning:

7/1/99

Ending:

6/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	0.00%	Clearbrook - Lattof Commons	Rolling Meadows	Clearbrook	Rolling Meadows	Not for profit
None	0.00%	Clearbrook West	Rolling Meadows	CRH, Inc.	Rolling Meadows	Not for profit
None	0.00%	Clearbrook East	Rolling Meadows	Clearbrook	Rolling Meadows	Not for profit
None	0.00%	Wright Home	Gurnee	Augustana	Rolling Meadows	Not for profit

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☒

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Clearbrook - Wright Home # 0044297 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Clearbrook - Wright Home# 0044297

Report Period Beginning:

7/1/99Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Program costs	15,114,878		\$ 86,744	\$	936,057	\$ 5,372	1
2	17	Administrative	Program costs	15,114,878		478,478	478,478	936,057	29,632	2
3	19	Professional services	Program costs	15,114,878		73,812		936,057	4,571	3
4	20	Fees, subscriptions and dues	Program costs	15,114,878		30,022		936,057	1,859	4
5	21	Clerical and general	Program costs	15,114,878		708,925	347,904	936,057	21,545	5
6	22	Employee benefits	Program costs	15,114,878		210,332		936,057	13,026	6
7	23	In service training and education	Program costs	15,114,878		158,460	104,930	936,057	9,813	7
8	25	Other admin transportation	Program costs	15,114,878		14,835		936,057	919	8
9	26	Insurance	Program costs	15,114,878		17,005		936,057	1,053	9
10	32	Interest	Program costs	15,114,878		32,937		936,057	2,040	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,811,550	\$ 931,311		\$ 89,830	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	HUD		X	Purchase of facilities	\$4,792.41	03/20/96	\$ 662,300	\$ 639,772	03/20/37	8.3800	\$ 53,980	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$4,792.41		\$ 662,300	\$ 639,772			\$ 53,980	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 662,300	\$ 639,772			\$ 53,980	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **Clearbrook - Wright Home**# **0044297** Report Period Beginning: **7/1/99** Ending: **6/30/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	2
3. Under or (over) accrual (line 2 minus line 1).	\$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 43,419

B. General Construction Type:
 Exterior
 Cedar Siding
 Frame
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building	43,419	1992	\$ 82,796	1
2					2
3	TOTALS	43,419		\$ 82,796	3

Facility Name & ID Number Clearbrook - Wright Home

0044297

Report Period Beginning:

7/1/99

Ending:

6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	15		1992	1992	\$ 739,826	\$ 18,479	40	\$ 18,479	\$ 0	\$ 119,251	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Bathroom Renovation			1999	2,358	236	10	236		275	9
10	Carpet			1999	11,071	2,272	5	2,272	(0)	3,117	10
11	Memorial garden			1999	36,163	1,810	20	1,810		2,685	11
12	Parking lot renovation			2000	20,212	395	25	395		395	12
13	Gazebo			2000	6,500	217	15	217		217	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 816,129	\$ 23,408		\$ 23,408	\$ (0)	\$ 125,940	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 63,639	\$ 7,304	\$ 7,304	\$	7	\$ 57,867	37
38	Current Year Purchases	21,454	1,958	1,958		10	1,958	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 85,093	\$ 9,262	\$ 9,262	\$		\$ 59,825	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient care	Ford Van	1994	\$ 32,820	\$ 6,564	\$ 6,564	\$		\$ 29,538	42
43										43
44										44
45										45
46	TOTALS			\$ 32,820	\$ 6,564	\$ 6,564	\$		\$ 29,538	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,016,839	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 39,234	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 39,234	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (0)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 215,303	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>80</u>
		HOURS PER AIDE <u>44</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	<u>2</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	<u>2</u>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language Development Therapist		hrs								2
2	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
10	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	374,296	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		2,060,227	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		88,017	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		107,677	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from temporarily restricted		876,269	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	3,506,486	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,385,317	13
14	Buildings, at Historical Cost		13,487,032	14
15	Leasehold Improvements, at Historical Cost		277,881	15
16	Equipment, at Historical Cost		3,290,913	16
17	Accumulated Depreciation (book methods)		(6,133,869)	17
18	Deferred Charges		242,261	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits		115,896	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	12,665,431	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	16,171,917	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	442,596	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		525,863	29
30	Accrued Salaries Payable		777,784	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		18,531	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See page 25		200,142	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	1,964,916	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,640,727	40
41	Bonds Payable		3,700,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to permanently restricted		536,523	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	6,877,250	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	8,842,166	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,329,751	\$ 7,329,751	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,329,751	\$ 16,171,917	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,978,009	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,978,009	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(102,358)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Consoldated net income of Gurnee	454,100	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 351,742	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,329,751	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 750,424	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 750,424	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	115,157	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 115,157	23
D. Non-Operating Revenue			
24	Contributions	11,050	24
25	Interest and Other Investment Income***	1,859	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,909	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 878,490	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	127,791	31
32	Health Care	561,136	32
33	General Administration	153,915	33
B. Capital Expense			
34	Ownership	93,214	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	44,792	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 980,848	40
41	Income before Income Taxes (line 30 minus line 40)**	(102,358)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (102,358)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Consolidated with our other programs

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Page 20

Facility Name & ID Number Clearbrook - Wright Home# 0044297Report Period Beginning: 7/1/99Ending: 6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,266	4,587	74,677	16.28	3
4	Licensed Practical Nurses	3,093	3,326	60,374	18.15	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	280	301	7,517	24.97	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	83	89	1,972	22.16	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,465	2,650	27,007	10.19	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,742	1,873	19,477	10.40	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	407	438	13,124	29.96	20
21	Assistant Administrator					21
22	Other Administrative	308	331	11,633	35.15	22
23	Office Manager					23
24	Clerical	1,693	1,820	24,992	13.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,199	2,364	25,747	10.89	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	21,265	22,866	214,259	9.37	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Coordinator</u>	467	502	8,928	17.78	33
34	TOTAL (lines 1 - 33)	38,268	41,147	\$ 489,707 *	\$ 11.90	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	124	\$ 4,323	Line 15	35
36	Medical Director			Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		716		39
40	Physical Therapy Consultant	56	3,806		40
41	Occupational Therapy Consultant	176	7,034		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychiatric</u>	13	3,345		46
47	<u>Neurological</u>	9	3,250		47
48	<u>Medical + Laboratory</u>		4,262		48
49	TOTAL (lines 35 - 48)	378	\$ 26,736		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	Line 15	50
51	Licensed Practical Nurses			Col 3	51
52	Nurse Aides	5,127	92,282		52
53	TOTAL (lines 50 - 52)	5,127	\$ 92,282		53

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,585 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 44,792
This amount is to be recorded on line 42 of Schedule V. _____
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions. _____
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Blackman Kallick Bartelstein The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. Yes
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Schedule V Line 6 Maintenance other

Communications	7,002
Postage & Shipping	448
FF&E repairs and maintenance	2,855
Care of building and grounds	12,377
Trash removal	1,596
Miscellaneous rent	2,624
	<u>26,902</u>

Schedule V Line 27 Other

Specific assistance to individuals	586
Other professional fees-Dept of Public Health	33
Audit fees- paid to Blackman, Kallick, Bartelstein CPA	7,500
Gas & Oil	614
Vehicle repairs and maintenance	2,238
Moving and recruiting	9,687
Staff medical exams	1,034
Bank and brokerage fees	203
Miscellaneous	291
	<u>22,186</u>

Schedule VIII Line 7 Inservice training

	Clearbrook Total	Augustana
Salaries	104,930	3,840
Employee benefits	17,698	648
Occupancy	18,125	663
Insurance	639	23
Other	11,855	434
	<u>153,247</u>	<u>5,608</u>

Clearbrook ID # 0030023/0033027/0033035/0037820

Reconciliation of cost reports to audit

Cost reports

Clearbrook East	739,152
Clearbrook West	659,647
Clearbrook Center	4,283,829
Augustana Group Home	<u>980,848</u>
	6,663,476
Less provider tax included in revenue in audit	<u>(348,684)</u>
	6,314,792

Audit

ICF			5,803,351
Subtract expenses related to special grant money			(2,500)
Clinic net of allocation to CILA	539,047	-25105	<u>513,942</u>
			6,314,793

Schedule XV Balance Sheet/Schedule of changes in equity

These statements are prepared on a consolidated basis on the Unrestricted Fund per the audit. We do not maintain separate balance sheets per program.

Schedule XV Balance Sheet Other current liabilities

Deferred revenue	79,257
Due to related parties	60,000
Due to government agencies	38288
Other liabilities	12,178
Other accrued expenses	<u>10,419</u>
	200,142

Clearbrook

ID # 0033035/0033027/0030023

Schedule VIII Line 2 and 21 Salaries

NAME	TITLE	SALARY
APPLETON,KATHLEEN	VICE PRESIDENT-FINANCE	85,708
BAEZ-LOPEZ,ROSA	VICE PRESIDENT-HUMAN RESOURCE	63,630
BELLOMO,STACEY A.	PROGRAM COORDINATOR	52,000
FRICK,DONALD LEE	MIS	62,478
LA-MELL,CARL	PRESIDENT	131,300
TURI,JAMES A	VICE PRESIDENT-BUS OPERATIONS	83,361
		<u>478,478</u>
ANDERSEN,BERNADETTE	ADMINISTRATIVE ASSISTANT	35,977
WEBER, KATHLEEN	PAYROLL	12,184
CALDERON,TANIA	ADMINISTRATIVE ASSISTANT	27,530
CHEN, KENNETH	DATA ADMINISTRATOR	40,462
COPELAND,ELIZABETH	RECEPTIONIST	15,540
KAUFMAN,JOYCE	CLERICAL-HR	31,904
LOMBARDI,ANITA N	PAYROLL	36,333
PAULS,LESLIE	ACCOUNTANT	34,000
RIX,JOHN	CLERICAL-AR	27,192
ROBINSON,DENISE	ADMINISTRATIVE ASSISTANT	28,096
TALAGA,ROSEMARY	CLERICAL-AP	24,298
WILCOXSON,TONYA	CLERICAL-AR	34,387
		<u>347,904</u>

Cell: A5

Comment: [Microsoft JET Created Table]0051010100707

Cell: F7

Comment: [Microsoft JET Created Table]003101007